Innovative strategies to enhance HIV service delivery among female sex workers during the COVID-19 pandemic in Zimbabwe

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A B S T R A C T

Globally, access to HIV services by key populations has always been a challenge even prior to the emergence of Coronavirus disease in 2019 (COVID-19). With reference to Zimbabwe, sex workers experienced challenges in accessing HIV services as was exacerbated by the pandemic and related lockdown restrictions. In the given context, it was critical to develop innovative approaches to increase female sex workers' access to HIV treatment. Such approaches help prevent treatment interruption and contribute to HIV epidemic control. The study aimed to explore and describe the innovative approaches that were adopted to enhance HIV service delivery among female sex workers during the COVID-19 pandemic in Zimbabwe. A qualitative, descriptive phenomenological design was used to attain the study's objective. Ten purposefully sampled participants were individually interviewed following a semi-structured interview guide. Data were analyzed using Colaizzi's seven steps. The research findings yielded the following themes: participants received differentiated HIV service delivery through community-based outreach, virtual psychosocial interventions, and support systems through peers, family, and institutions. The innovative approaches to promote HIV service delivery during COVID-19 enhanced female sex workers’ access to differentiated person-centred care and promoted treatment continuity. Community workers were also vital in supporting their peers’ treatment adherence. The lessons drawn from this study are critical and can be utilized in different settings.

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I N T R O D U C T I O N

This paper reports on innovative strategies to promote female sex workers’ access to HIV treatment during the Coronavirus disease in 2019 (COVID-19), in Bulawayo, Zimbabwe. Prior to the emergence of the pandemic, sex workers in Zimbabwe (as in other countries) had challenges accessing HIV services. The illegality of sex work, stigma and discrimination attached to HIV contributed to these challenges (Moyo & Machere 2021; Duby et al., 2018). Dimitrov et al. (2022) additionally reported barriers to accessing HIV treatment that include long distances to healthcare facilities, financial burden to the user, long waiting times, and overburdened healthcare facilities.

COVID-19 and subsequent lockdowns created significant barriers for sex workers accessing HIV treatment in Zimbabwe (Mavhundu-Mudzusi & Moyo, 2022). Female sex workers from Bulawayo reportedly often missed treatment appointments due to a lack of travel authorisation letters (required when passing through police roadblocks) to access their monthly treatment supplies (Mavhundu-Mudzusi & Moyo, 2022). In Malawi and Kenya, Kachale et al. (2021), reported similar challenges relating to HIV treatment access among young women and adolescents attributed to COVID-19 lockdowns. Additionally, Nyashanu et al. (2021), explored Zimbabwean women’s challenges in accessing antiretroviral treatment (ART) and reported transport problems, abuse by the police and soldiers at roadblocks, shortages of medication, lack of health check-ups, involuntary defaults on ART, and a shortage of personal protective equipment as contributing to poor treatment access. Women intending to collect HIV medicines during
COVID-19 restrictions complained of a lack of transport to treatment centres. The police and soldiers at roadblocks also often denied them access to treatment centres without permission letters (Nyashamu et al., 2021). These barriers resulted in treatment interruption in a number of cases, which could worsen affected individuals quality of life.

Sex workers were at risk of running out of HIV medicines due to several restrictive measures meant to contain the spread of COVID-19 (Nyashamu et al., 2021). They were frustrated and did not know where to obtain their next treatment dose. Moreover, according to UNAIDS (2020a), more relapses and defaults were likely to occur as there was no communication on how patients were to access their treatment, and most were fearful of disclosing their HIV status out of fear of stigma (UNAIDS2020a).

In response to COVID-19, adaptations were made in HIV service delivery to facilitate uninterrupted access to ART, simultaneously decongesting healthcare facilities. This was achieved by accelerating differentiated service delivery for HIV treatment, adapted during the pandemic (Grimsrud & Wilkinson, 2021). This approach puts the person at the centre and adapts HIV services to meet their needs and expectations (WHO, 2016). Several strategies were utilised to ensure the health systems effectively responded to the COVID-19 outbreak. The most significant strategy was extending the multi-month dispensing (MMD) of antiretrovirals (ARVs) to enhance client-centred differentiated care and promote treatment continuity (Bailey, 2021; Pollard, 2021). Other approaches entailed reducing the frequency of clinical consultations, enabling community ARV refills, utilising community-based models, and integrating/aligning the delivery of TB preventative therapy (TPT), non-communicable disease and ARV medicines (Grimsrud & Wilkinson, 2021; Kintu, 2020).

In the United States of America, alternative options to reduce the HIV epidemic during COVID-19 included telehealth consultations, home-based medication delivery, and increased facilitation of access to the Ryan White HIV/AIDS programme (Armstrong, 2020). In response to threats that COVID-19 could interrupt ART surge progress, Nigeria designed and implemented several ART surge strategies, such as: intensified focus on community-based rather than facility-based care; HIV case findings’ initiation on three-month ART starter packs; expansion of ART distribution through community refill sites; and broadened access to MMD (3-6 months ARVs) among people living with HIV (Boyd et al., 2021). Another strategy that proved effective in enhancing treatment continuity was the use of community workers as demonstrated by Family Health International 360 (2020).

Ultimately, several treatment modifications were made to promote access to HIV services during COVID-19 lockdowns, including scaling up telehealth strategies (Dandachi et al., 2020). A study conducted in Thailand by Rogers et al. (2020) demonstrated that telehealth follow-up on ART delivery was a feasible and convenient strategy to facilitate treatment continuity, particularly during the COVID-19 pandemic. In addition, evidence has shown that healthcare providers viewed telehealth as critical during the pandemic, as it assisted in minimising the spread of the virus through social contact in healthcare facilities and during travel. It also increased clients’ follow-up options through the provision of counselling and psychosocial support using online platforms (Golin et al., 2020; Mgbako et al., 2020; Dandachi et al., 2020). Prior research by Wang et al. (2022), demonstrated the importance of innovative intervention strategies that address psychosocial (mental health) factors among people on ART to sustain their HIV treatment outcomes and well-being. This paper sought to explore and describe the innovative approaches that were adopted to enhance HIV service delivery among female sex workers during the COVID-19 pandemic in Zimbabwe.

Background and context for the study

According to Mhazo and Maponga (2022), Zimbabwe is characterised by a fragile economy and political instability and these influence the performance of the country’s health system. In Zimbabwe, sex work is illegal, and this vulnerable group also experiences unfriendly and discriminatory treatment as it accesses healthcare services (Moyo & Macherera, 2021). The illegal nature of sex work in Zimbabwe and the high rate of unemployment render sex workers more vulnerable. Evidence has also demonstrated that the COVID-19 restrictive measures and criminalisation of sex work exacerbate the female sex workers’ vulnerability and has negative implications on HIV treatment outcomes (Footer et al., 2016; Busza et al., 2017). A study conducted in Kenya by Gichuna et al. (2020) found that measures by the government to contain the spread of COVID-19 made it difficult or impossible to access health care services. Another study in Zimbabwe by Moyo et al. (2022) indicated that HIV services access by sex workers has always been a challenge even before the emergence of the COVID-19 pandemic. COVID-19-related studies in Africa (UNFPA, 2020; El-Sadr & Justman, 2020) established that the disruption of health care services because of COVID-19 restrictive measures may result in poor treatment outcomes particularly for key populations such as the sex workers. The prevailing situations formed the baseline for the responsive measures in the form of developing and adopting innovative approaches in HIV care during the COVID-19 pandemic.

Research and Methodology

Design

A qualitative approach, following a descriptive phenomenological design, was employed to explore and describe the innovative approaches that were adopted to enhance HIV service delivery among female sex workers during the COVID-19 pandemic in Zimbabwe. The design was chosen for its ability to explore and describe the lived experiences of those who lived the research phenomenon (Polit & Beck, 2021; Ellis, 2021; Qutoshi, 2018). The design also allowed spontaneous responses that revealed...
participants’ natural feelings, behaviour, and attitudes (Qutoshi, 2018; Giorgi, 2020). The researchers chose this design since it enables participants to reflect, discover and access the consciousness about the phenomenon under study (Willis et al., 2016).

This research design was created by Husserl, who posited that bracketing is vital in descriptive phenomenology. Though complete bracketing is not possible, the researchers put aside their preconceived ideas and biases related to the research phenomenon in order to be open to the participants’ experiences (Wertz, 2011; Lopez & Willis, 2004). According to Rau (2020), bracketing one’s biases is important to become open to participants’ responses to open-ended questions on the phenomenon under study.

Even though complete avoidance of bias could not be possible in qualitative studies, the researcher avoided leading questions when collecting data and often used open-ended questions to allow the participant to respond freely. The researcher also minimise bias when asking the neutral persons who were colleagues and supervisors to read through the interview questions and give input. During the interviews, the participants were given time to narrate their interviews without interruptions.

Study setting

In Zimbabwe, where this study was conducted, sex work is illegal. However, the country faces high rates of unemployment, and many women resort to sex work out of desperation. Because of the criminal nature of their work, sex workers face stigma and discrimination when they make efforts to access HIV services (Moyo & Machere, 2021). The emergence of COVID-19 further aggravated their vulnerability and reduced their access to healthcare services.

The study setting was Bulawayo, Zimbabwe. The city has two central hospitals, 17 health facilities and two private facilities that provide HIV services to key populations. The research population was female sex workers who met the following criteria: self-identifying as female sex workers, willing to participate, owning a cell phone, aged 18 years and older, and receiving ART or PrEP (pre-exposure prophylaxis) from any healthcare facilities in Bulawayo.

Study population and sampling

The population for the study was female sex workers in Bulawayo, Zimbabwe. The researcher included all female sex workers who identified as such, aged 18 years and older, receiving ART or PrEP at any private or public healthcare facility in Bulawayo, and owned a cell phone. Those who met these criteria but were unavailable during the data collection period were excluded from the study. None of the participants were transgender sex workers identifying as females. Purposive sampling, combined with snowballing, was used to identify study participants. The researcher (second author) accessed the first two participants as referrals from the staff working at healthcare facilities that provide services to key populations, including female sex workers. These two participants led the researcher to other sex workers, until data saturation was reached through snowball sampling.

Data collection

One-on-one in-depth interviews were conducted with each participant in a selected private room in the healthcare facility from December 2020 to March 2021. A semi-structured interview guide comprising one central question was used with all participants. The central question was: Can you share your experiences on how you managed to access HIV services during the COVID-19 pandemic? There were no pre-set probes for the study, but the researcher followed up on the central question with open-ended questions/probes based on participants’ responses/cues. The semi-structured interview guide was followed as advocated by Polit and Beck (2021), enabling the researcher to delve deeper into the participants’ experiences. According to Dejonckheere and Vaughn (2019), semi-structured interview guides are used to collect open-ended data that could explore participants’ thoughts, feelings and beliefs about the phenomenon under study. Researchers are thereby able to delve deeper into personal and sometimes even sensitive issues.

The interview guide was piloted with two participants who were not part of the main study. The interview guide was found useful in answering the research question, and no changes needed to be made since the participants answered the questions with ease. The interviews were audio-recorded, and field notes were taken as the researcher observed participants’ body language (Creswell &Creswell, 2018). Interviews were conducted by the second author as she was fluent in IsiNdebele and English, which are spoken in Bulawayo. Data saturation was reached at participant number seven, and the researcher continued to interview three additional participants to confirm data saturation; no new themes emerged. Data saturation is a point at which additional data do not lead to any new emergent themes (Saunders et al., 2018). Ten participants were thus interviewed. This sample of 10 participants is justifiable by Polit and Beck (2021), who posit saturation could be achieved in phenomenology with 10 or more participants. Similarly, Ellis (2021) suggests a sample of six to 20 is adequate for saturation in phenomenology studies. Each interview lasted 45–60 minutes.

Data analysis

Colaiazzi’s data analysis steps were followed in this study, as guided by Giorgi (2020). Data were translated and transcribed verbatim by the second author, who is fluent in both IsiNdebele and English. In step one, transcripts were read repeatedly by each researcher independently to make sense of them. In step two, significant statements were extracted; these were either phrases or sentences that pertained to the phenomenon being investigated. For step three, quotes were broadly categorised, generating themes from multiple statements that convey similar meanings. Step four entailed creating themes from formulated meanings obtained from steps one to three. In step five, an exhaustive description of all data generated during steps one to four was compiled. Step six required the
researchers to summarise and identify a fundamental structure of the phenomenon under study. In step seven, the researchers entered discussions with experts and independent reviewers to reach a consensus on the emergent themes and sub-themes to ensure confirmability. Member checking was done telephonically with five of the participants to ensure the results were participants’ true reflections (Colaizzi, 1978). Emergent themes and sub-themes were then developed with inputs from the participants.

**Measures to ensure the study’s trustworthiness.**

The study’s trustworthiness was promoted through the following measures, as described by Lincoln and Guba 1985 as cited in De Vos et al. (2016): credibility, confirmability, transferability, and dependability. Credibility was ensured through member checking, and the second author provided the data interpretations for participants to review (Williams & Kimmons, 2022). Five participants were thus contacted and received a summary of the transcripts, enabling them to agree or disagree with the findings as a true reflection of what transpired during the interviews. Participants confirmed that the emergent themes in the summary were true reflections of their experiences. In addition, all interviews were audio-recorded and transcribed verbatim to enhance credibility.

Confirmability was ensured by involving a different researcher during data analysis to verify the findings, conclusions, interpretations, and recommendations. Transferability was established by describing each research step taken from the start of the research project to the development and reporting on findings. Moreover, research reports were maintained throughout the study. Dependability was promoted through a detailed description of the research process to enable other researchers to replicate the study (Beck, 2019). Records on the data collection process were kept enhancing the study’s dependability.

**Ethical considerations**

To comply with the ethics of research, the study was conducted after receiving ethical approval from the Medical Research Council of Zimbabwe (Ethical clearance Number: MRCZ/A/2659). Permission to conduct the study was also received from the hospital directors in Bulawayo, Zimbabwe. Each participant signed a voluntary informed consent form before commencing the interviews. Pseudonyms were used instead of participants’ real names, and their privacy and confidentiality were ensured throughout the study (De Vos et al., 2016). Information leaflets were handed to participants during recruitment, outlining the research purpose, their rights, and the objectives of the study.

**Results**

Ten female sex workers between the ages of 31 and 45 participated in this study. All participants received PrEP or ART from public or private treatment facilities in Bulawayo, Zimbabwe. They had been on treatment from two to eight years. Most of the participants were unemployed outside their sex work. Table 1 presents the participants’ biographic profiles, followed by Table 2, displaying the emergent themes and sub-themes derived from the analysed data.

**Table 1: Participants’ biographic data**

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Age range in years</th>
<th>Level of education</th>
<th>Number of children</th>
<th>Employment status other than sex work</th>
<th>Service</th>
<th>Duration of accessing treatment</th>
<th>Treatment access site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andy</td>
<td>36-40 years</td>
<td>O Level</td>
<td>1</td>
<td>Domestic worker</td>
<td>PrEP</td>
<td>2 years</td>
<td>Private</td>
</tr>
<tr>
<td>Sophy</td>
<td>31-35 years</td>
<td>Form 2</td>
<td>4</td>
<td>Not employed</td>
<td>PrEP</td>
<td>3 years</td>
<td>Private</td>
</tr>
<tr>
<td>Lina</td>
<td>31-35 years</td>
<td>O Level</td>
<td>2</td>
<td>Hairdresser</td>
<td>ART</td>
<td>2 years</td>
<td>Public</td>
</tr>
<tr>
<td>Lizzy</td>
<td>41-45 years</td>
<td>Grade 7</td>
<td>3</td>
<td>Not employed</td>
<td>ART</td>
<td>4 years</td>
<td>Public</td>
</tr>
<tr>
<td>Lilly</td>
<td>31-35 years</td>
<td>O Level</td>
<td>3</td>
<td>Shopkeeper</td>
<td>ART</td>
<td>8 years</td>
<td>Private</td>
</tr>
<tr>
<td>Monica</td>
<td>41-45 years</td>
<td>Form 2</td>
<td>4</td>
<td>Not employed</td>
<td>ART</td>
<td>4 years</td>
<td>Private</td>
</tr>
<tr>
<td>Lora</td>
<td>36-40 years</td>
<td>O Level</td>
<td>2</td>
<td>Hairdresser</td>
<td>ART</td>
<td>3 years</td>
<td>Public</td>
</tr>
<tr>
<td>Mary</td>
<td>31-35 years</td>
<td>O Level</td>
<td>2</td>
<td>Not employed</td>
<td>PrEP</td>
<td>2 years</td>
<td>Private</td>
</tr>
<tr>
<td>Virgy</td>
<td>41-45 years</td>
<td>Grade 7</td>
<td>3</td>
<td>Not employed</td>
<td>ART</td>
<td>3 years</td>
<td>Private</td>
</tr>
<tr>
<td>Pearl</td>
<td>36-40 years</td>
<td>Tertiary</td>
<td>2</td>
<td>Not employed</td>
<td>PrEP</td>
<td>2 years</td>
<td>Private</td>
</tr>
</tbody>
</table>
Table 2: Emergent themes and sub-themes reflecting female sex workers’ experiences of treatment support

<table>
<thead>
<tr>
<th>Emergent themes</th>
<th>Sub-themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Differentiated HIV service delivery</td>
<td>Community outreach</td>
</tr>
<tr>
<td></td>
<td>Community-based MMD of medicines</td>
</tr>
<tr>
<td>Virtual psychosocial interventions</td>
<td>Utilisation of telehealth case management</td>
</tr>
<tr>
<td></td>
<td>Counselling</td>
</tr>
<tr>
<td>Support systems</td>
<td>Peer support</td>
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<tr>
<td></td>
<td>Family support</td>
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<tr>
<td></td>
<td>Institutional support</td>
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</tbody>
</table>

The emergent themes illustrate the efforts made to enhance female sex workers’ access to HIV services during the COVID-19 period. The following themes emerged following data analysis: participants received differentiated HIV service delivery through community-based outreach, virtual psychosocial interventions, and support systems through peers, family, and institutions. The following sub-themes related to the emergent themes: community outreaches; community based MMD; utilisation of telehealth case management; counselling; peer, family, and institutional support.

**Differentiated HIV service delivery.**

This section focuses on one of the emergent themes: differentiated service delivery. This strategy was utilised to increase access to and prevent treatment interruptions. The theme is discussed under two sub-themes: community outreach and community based MMD of medicines.

**Community outreach**

Whilst some services could be provided virtually and remotely, some clients still required clinical care and in-person support during the COVID-19 pandemic. Providers of care had to conduct outreach services (with limited interaction), meet clients in the community and or in their homes. Participants had access to a number of services, ARVs and PrEP, condoms, some counselling during community outreaches. Participants shared:

“Service providers came to the community to provide the services we required since it was difficult for us to visit the healthcare facilities due to the COVID-19 restrictions. An arrangement was made for us to meet the healthcare workers to access our ARV medicines, get condoms. The clinic would call to find out the preferred/convenient place to deliver the medicines. This arrangement ensured privacy and was very convenient since movement was a challenge” (Lilly)

“Medicines were being distributed in the community, but for me I didn’t like the idea of them coming home, I thought that would interfere with my privacy and the neighbours would know that I am on ART, so I opted to go meet them by the nearby shopping centre” (Virgy)

**Community-based MMD of medicines**

Community-based MMD of medicines was one of the approaches employed to take services closer to the communities, as the following extracts demonstrate:

“My three months supplies of PrEP medicines were delivered at my doorsteps, and this made life easy for me. I was able to continue taking my medicines without any interruption” (Mary)

“When the tablets were almost finished, a nurse from a private clinic phoned to check on where to deliver my medicines. They delivered six months supplies of ART medicines at home. I felt excited and relieved” (Lina)

**Virtual psychosocial interventions**

This emergent theme focused on psychosocial interventions that were implemented to prevent treatment non-adherence and interruption. The theme is explored under the following sub-themes: telehealth case management and counselling.

**Utilisation of telehealth in case management**

In an effort to prevent and contain the spread of COVID-19 and facilitate treatment continuity, service providers from treatment centres used telehealth strategies to facilitate virtual case management, as mentioned by the following participants:

“The nurse from my treatment centre would send a WhatsApp/sms message to remind me about the due date for my medication pick-up as well as collection of viral load specimen that was due. She would also find out about the safe space where I could meet her for my treatment” (Monica)
“My nurse counsellor used to phone me to check on whether I was adhering to my medicines and to find out if I had any challenges. I would also call should I have concerns” (Lilly)

“I had social challenges that were making me forget to take my medicines on time. I received counselling through a WhatsApp call from a peer counsellor (expert client), that assisted me so much. Thereafter, I continued to adhere to taking ARV medicines” (Lina)

Counselling

Participants received telephonic support from sex-worker organisations in the form of counselling, as reflected below:

“The fact that the situation forced me to stop PrEP was also another issue that affected me psychologically. I received counselling through the phone from a counsellor working in one organisation that provides services for key populations” (Sophy)

The participants also received counselling support from peers in the sex-worker community:

“During the lockdown, I continuously received WhatsApp counselling and encouragement messages from my peers that work under the organisation that support us to continue adhering to my ARV medicines” (Lora)

Support system

In response to the challenges associated with COVID-19 restrictive measures, the participants indicated they relied on support from their peers, non-organisational institutions, and families to continue accessing HIV services and adhere to their prescribed medicines. This emergent theme is therefore discussed under the following sub-themes: peer support, family support, and institutional support.

Peer support

The participants indicated that the support they received from their peers played a key role in their medication adherence. This support was largely provided through digital platforms like WhatsApp, as shared in the following excerpts:

“Peer interactions continued during the lockdown. We supported each other to continue taking medication during the lockdown, this was done mainly through WhatsApp” (Pearl)

“Other peers were calling me to check how I was coping as well as delivering my ARV medicines at a place close home and convenient to me” (Lora)

“The peer counsellor who normally delivers my PrEP supplies has always been supportive. She continued to chat with me on WhatsApp to encourage me to continue taking my tablets for pre-exposure prophylaxis” (Andy)

Family support

The participants indicated their family members assisted them in taking their medication during times of lockdown. Participants explained:

“I disclosed my HIV status to my sister. She has always been my major source of support to continue taking treatment, even during the lockdown” (Lizzy).

“My family supported with food and money for rentals. My cousin would call to remind me of the scheduled day for medicine pick-up. They continued to check on me through WhatsApp messages or calls” (Sophy)

Institutional support

The participants received support from the healthcare facilities where they typically received their ARVs, and from facilities offering support services for key populations. In addition, participants received food hampers from a non-governmental organisation:

“It was difficult to continue taking medication on an empty stomach. However, we were assisted by this non-governmental organisation, that provided us with food hampers and through the phone” (Monica)

Treatment centres supported participants by providing services closer to their homes. The following excerpts reflect:

“The nurses and other community workers were supportive and brought services closer to our homes. This made the situation better and easier for me, in that I did not need to look for transport to go to the health facilities” (Virgy)

“In my previous visit to the healthcare facility, I had indicated to the nurses that I was missing some doses of my medicines. This was because of the misunderstanding I was having with my partner and would even forget to take my ARVs at times. The nurse continued to call to check on me, I appreciated the support” (Monica)

Discussion

In response to the COVID-19 pandemic, and in a bid to decongest healthcare facilities and prevent treatment interruption, HIV service providers established innovative service delivery strategies. These innovative approaches assisted in addressing challenges associated
with accessing HIV treatment services during the pandemic. Strategies included, among others, expedited differentiated service delivery in the community, virtual psychosocial interventions, and support systems. Underpinning all these strategies was the need to take HIV services to the communities using a differentiated service delivery approach. This approach is recommended by World Health Organisation (WHO) and the Joint United Nations Programme on HIV/AIDS (WHO, 2020; UNAIDS, 2020b), and was reported to be effective in other settings (UNPFA, 2020b; Kiriga et al., 2020).

The study also found that telehealth was a two-way process where the service provider would phone the client to establish a convenient time for medicine delivery, or the client could call back. Service providers and clients used various forms of telecommunication such as voice calls, SMS or WhatsApp messages or calls. Other studies have demonstrated that telehealth was critical in improving adherence support and preventing treatment interruption (Golin et al., 2020; Monaghesh & Hajizadeh, 2020; Chauhan et al., 2020; Zhai et al., 2020). This is in keeping with WHO recommendations and protocols (WHO, 2016). In other settings, access to HIV services was promoted during COVID-19 lockdowns through several modifications in terms of scaling up the telehealth strategies described (Dandachi et al., 2020; UNAIDS & WHO, 2022). According to UNAIDS/WHO (2022), virtual intervention approaches form an integral part of HIV service delivery, as it supports case management and differentiated service delivery models, such as community-based virtual adherence counselling and viral load-tracking services.

The study determined that other adjustments in responses to the pandemic included MMD of both ART and PrEP. Chinese, Philippine, and Ugandan participants reported similar difficulties reaching ART clinics during COVID-19, as reported in this study (Guo et al., 2020; Linnemayr et al., 2020). Innovative approaches to resolving such challenges included delivering up to six months’ supply of medication to community pharmacies. These medicines were delivered to the community, clients’ homes, or preferred safe spaces – an act supported by the WHO (2020) recommendations. In support of these innovations, Family Health International 360 (2020), claims that monthly medicines dispensing (MMD) is one of the critical approaches to sustaining gains, treatment continuity and viral suppression. Evidence from Grimsrud and Wilkinson (2021) and Kintu et al., (2020) have also established that MMD is an effective strategy for enhancing treatment continuity, particularly during emergency situations such as COVID-19. The use of community-based models for ARV refills was critical in reducing the frequency of clinical consultations. The MMD of ARVs ultimately enhances client-centred differentiated care and facilitates treatment continuity (Bailey et al., 2021; Pollard et al., 2021).

The findings indicate that, although there were lockdown restrictions, female sex workers continued to interact with each other using WhatsApp. This type of interaction acted as a means of support and encouragement to continue taking their medications. This is consistent with findings elsewhere demonstrating the effectiveness of the peer support system (Grimsrud & Wilkinson, 2021). Some studies have also shown the significant role of peer support in enhancing adherence and treatment continuity among men who have sex with other men (Benoit et al., 2020; Graham et al., 2018). These peers are typically assisted by non-governmental health and advocacy organisations that provide sensitive services and deliver ART, PrEP, and food directly to female sex workers (Moyo & Macherere, 2021; Slabbert et al., 2017). The element of food is important because some participants indicated they had discontinued treatment because it was difficult to take their medication on an empty stomach. In this study, participants thus received material support in the form of food supplies and money for rent from family members and peers, the sex-worker community, as well as two non-governmental organisations. These provided food supplies as well as ART and PrEP community refills.

Similar findings were shared in a study by Dimitrova et al. (2022), in that family members and close friends were willing to provide social assistance, medications, financial support and emotional assistance. In addition, some female sex workers received support to continue taking treatment during the lockdown from their relatives, to whom they had disclosed their HIV status. These findings are consistent with evidence from other studies (Makhakhe et al., 2019; Chen et al., 2020; Yin et al., 2018) that demonstrated the significant role family played in adherence support.

Conclusion

While COVID-19 was an emergency, HIV treatment centres responded with innovative strategies that facilitated treatment continuity. These strategies included the use of community outreaches, telehealth to facilitate, among others, follow-up, adherence, psychosocial support and MMD of ARVs. Such approaches enhanced the use of differentiated person-centred care. One of the key lessons learnt in the provision of such innovative interventions is that the key populations’ peers play a pivotal role in client follow-ups, providing psychosocial support, as well as delivering ARVs and PrEP supplies to the community or at the client’s doorstep/safe space. The lessons learnt in response to the pandemic can be applied in other settings in the country and region.

Pollard et al. (2021) note that in-home delivery may increase the risk of breaching confidentiality and disclosure of HIV status [Pollard et al., 2021]. Therefore, there is greater need to train community workers on issues of confidentiality. These findings are consistent with other study findings on the use of rapid, flexible, and person-centred responses to ART delivery in emergencies [Boyd et al. 2020, Gamaleldin, 2022]. These responses can also be adopted even in normal circumstances as alluded to by [Khan et al. 2021]. Routine patient care can be improved if these alternatives can be adopted and restructured outside COVID-19. Evidence from these findings shows that when resources are channelled through multi-stakeholder collaboration, HIV services can be improved. Khan et al. (2021) posit that the scaling up differentiated person-centred HIV services is both feasible and sustainable.
Beside the strength shared in this study, the study had some limitations. The study was conducted in one district in Zimbabwe. Due to the nature of the study being a descriptive phenomenology study, only ten participants were interviewed as guided by saturation.

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References


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